STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	04/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY VILLAGE	3518 S SHELBY ST INDIANAPOLIS, IN 46227

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 21, 22, 23, 24, 25, 28, and 29, 2014 Facility number: 000142 Provider number: 155237 AIM number: 100266940 Survey Team: Dorothy Plummer, RN-TC Marsha Smith, RN Patsy Allen, SW (April 22, 23, 24, 25, 28, 29, 2014) Census bed type: SNF/NF: 95 Total: 95 Census payor type: Medicare: 10 Medicaid: 69 Other: 16 Total: 95 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 05, 2014; by Kimberly Perigo, RN.	F000000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF POST SURVEY REVIEW on or after May 28, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure equipment used by residents was clean and in good repair. (Resident #16, Resident #49, Resident #51) Findings include: 1. On 4/22/14 at 11:35 a.m., Resident #51 was observed walking with a walker in the hallway to the dining room. The walker had the resident's name on it and was observed to be soiled with smeared food stains, different colored dried fluid stains from the hand grips down the frame of the walker, and was covered with an accumulation of dirt/dust. On 4/29/14 at 12:00 p.m., Resident #51 was observed in the dining room with her walker sitting beside her. The walker was observed to be soiled with smeared food stains, different colored dried fluid stains from the hand grips down the frame of the walker, and was covered with an accumulation of dirt/dust.	F000253	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Equipment for Resident #51, Resident #49, Resident #16, and Resident #100, and wheelchairs on the Cottage were cleaned and noted in good repair. How other Residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) will be taken? All other Residents have the potential to be affected. An audit was performed by the IDT team of all Resident equipment for all units including but not limited to wheelchairs and walkers to ensure all clean and in good repair. A new Resident equipment cleaning schedule was implemented on 5/14/14 for all units following nursing staff inservice by Director of Nursing/designee on 5/12/14 and 5/13/14 regarding cleaning Resident equipment. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? A new	05/28/2014

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	2. On 4/22/14 at 2:30 p.m., Resident #49 was observed sitting at the dining room table with a visitor. Resident #49 was watching the other residents who were doing an activity. A walker was sitting next to Resident #49. The walker had the name of Resident #49 on it and was observed to be soiled with smeared food stains, different colored dried fluid stains from the hand grips down the frame of the walker, and was covered with an accumulation of dirt/dust. The visitor of Resident #49 was observed to get a paper towel, wet it with water, and attempted to wipe the hand grips of the walker with the wet paper towel. On 4/25/14 at 12:15 p.m., Resident #49 was observed sitting in the dining room with a walker beside her. The walker was observed to be soiled with smeared food stains, different colored dried fluid stains from the hand grips down the frame of the walker, and was covered with an accumulation of dirt/dust. On 4/29/14 at 12:00 p.m., Resident #49 was observed in the dining room with her walker sitting beside her. The walker was observed to be soiled with smeared food stains, different colored dried fluid stains from the hand grips down the frame of the walker, and was covered with an accumulation of dirt/dust.		Resident equipment cleaning schedule was implemented on 5/14/14 following nursing staff inservice by Director of Nursing/designee on 5/12/14 and 5/13/14 regarding cleaning Resident equipment. Licensed nursing staff and Resident Customer Care Representatives will monitor cleaning schedule daily and staff not adhering to schedule will receive further education, disciplinary action up to and including termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and By what date the systematic changes will be complete? Director of Nursing/designee will monitor cleanliness and repair of Resident equipment with Resident Equipment CQI weekly x 4 weeks, monthly x 2, then quarterly until continued compliance is met for 2 consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, then an action plan will be developed to assure compliance. Date of compliance 5/28/14.	

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	3. During an observation of the Augusta's Cottage Unit, on 4/29/14 at 12:00 p.m., 2 wheel chairs,1 blue and 1 black, were observed at the nurse's station. The wheelchairs were observed to be soiled. The blue chair frame and seat had an accumulation of dirt, dried food crumbs, and dust. The upholstery on the arm rest was cracked and had missing pieces. The black chair was observed to be soiled. The frame and seat of the black chair had accumulation of dirt, dried food crumbs, and dust. The upholstery on the arm rest was cracked and had missing pieces. During an interview with Certified Nursing Assistant (CNA) #6 on 4/29/14 at 12:15 p.m., CNA #6 indicated wheelchairs were stored in the corner and were considered to be clean. CNA #6 indicated the blue chair belonged to Resident #100, but was not sure which resident owned the black chair. 5. On 4/21/14 at 2:20 p.m., Resident #16 was noted to be resting in bed. The Broda chair at the bedside was observed to be soiled with dried food crumbs, dried white fluid on the arm rest, the seat, and the cushion in the chair. On 4/22/14 at 2:40 p.m., Resident #16 was noted to be resting in bed. The Broda chair at the bedside was observed to be soiled with			

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	dried food crumbs, dried white fluid on the arm rest, the seat, and the cushion in the chair. During an interview with the DoN on 4/29/14 at 11:10 a.m., the DoN indicated the facility had recognized the lack of cleaning of the wheelchairs, and had implemented an action plan for correction on 4/18/14. The DoN indicated walkers and the equipment in the Augusta's cottage Unit were not included in the action plan. The DoN indicated the Broda chair of Resident #16 should have been cleaned on 4/24/14 on the night shift. During an observation with the Director of Nursing (DoN) on 4/29/14 at 11:15 a.m., Resident #16 was observed resting in bed. The Broda chair was in front of the closet. The chair was soiled with a dried white substance on the arm rest and the back of the chair, and the cushion in the chair had dried food crumbs on and under it. On 4/29/14 at 12:00 p.m., Resident # 16 was observed receiving her noon meal in a Broda Chair, in the Assist Dining Room. The chair was observed to be soiled with an accumulation of food crumbs, dirt and dust.			

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	3.1-19(f)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview, and record review, the facility failed to ensure a plan of care was in place for a resident who experienced a significant weight loss for 1 of 35 residents reviewed for implementation of care plans. (Resident #36) Findings include: The clinical record of Resident #36 was reviewed on 4/22/14 at 9:22 a.m.	F000279	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Resident #36 careplan review and update 5/15/14 to reflect significant weight loss potential related to diagnoses and diuretic use, Resident diet and preferences, and nutrition in regards to Resident having no natural teeth or dentures. How other Residents having the potential to be affected by the same deficient practice will be identified and	05/28/2014

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	Resident #36 was admitted to the facility following a hospital admission on 12/22/13. Diagnoses included, but were not limited to, cholecystectomy (removal of the gallbladder) due to cholelithiasis (gallstones) with acute cholecystitis (inflammation of the gallbladder) and obstruction, acute pancreatitis, hypertension, chronic kidney disease, congestive heart failure, atrial fibrillation, anemia, and diabetes. During a review of the recapitulation of physician's orders for April 2014, indicated daily weights were ordered on 12/27/13, and included instructions to call if the resident gained more than 3 pounds in 1 day. A review of a CAA (Care Area Assessment) Detail Report for Resident #36, for Nutritional Status, date 1/3/14, indicated a plan of care would be developed by dietary, and referenced CAA summary dated 1/9/14. A dietary note was not found in the CAA Summary nor in the dietary progress notes for 1/9/14. A registered dietician (RD) admission/30 day progress note dated 1/23/14 indicated Resident #36 had a significant weight loss of 7.1 % (percent) from admission		what corrective action(s) will be taken? All other Residents have the potential to be affected. Those Residents with significant weight loss or at risk for significant weight loss with diuretic use and Residents with no natural teeth or dentures had careplans audited and reviewed to ensure current dental services in place, as well as appropriate nutritional careplan. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? IDT will review all current Residents, new admissions, and readmissions to identify Residents with significant or potential for significant weight loss due to diuretic use and/or dental needs including those who refuse dental services. Nutrition careplans will be developed and/or revised accordingly by Dietary Manager/designee. IDT team will be inserviced by Director of Nursing Services Specialist/designee by 5/16/14 on completion of careplans timely and accurately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systematic changes will be complete?A Careplan CQI will be utilized weekly x 4 weeks, monthly x 2, then quarterly unitl continued compliance is met for 2 consecutive quarters. Results of	

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	weight of 226 pounds on 12/24/13 to weight on 1/21/14 of 210 pounds. The RD indicated the resident's usual body weight was 230 pounds, and weight loss could be attributed to diuretic usage, as Resident #36 had received furosemide (a diuretic) 120 mg daily since admission. The progress note indicated Resident #36 received a regular diet and large portions were added on 1/22/14, due to the weight loss. During a review of the plans of care for Resident #36, a plan of care with a problem start date 2/28/14, indicated Resident #36 received a regular diet, did not have any natural teeth, had agreed to try ground meats on 3/7/14, and had a potential for weight fluctuations due to diuretic therapy. Approaches included, but were not limited to, monitor weights, provide diet as ordered, and on 3/7/14 include large portions and ground meats per resident request. During an interview the RD on 4/25/14 at 2:30 p.m., the RD indicated she had reviewed the MDS information from 1/3/14 and saw the notation, "see dietary note 1/9/14," and did not look to see if a careplan had been developed at that time. The RD indicated she did not attend care conferences, and was not made aware of the lack of a plan of care to address		the audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, then an action plan will be developed to ensure compliance. Date of Compliance 5/28/14.	

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	dietary concerns as well as the significant weight loss Resident #36 had experienced. The RD indicated a plan of care to address the dietary concerns should have been in place prior to 2/28/14. 3.1-35(a) 3.1-35(b)1			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F000329	What corrective action(s) will be accomplished for those Residents	05/28/2014

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	Based on interview and record review, the facility failed to ensure bleeding times were monitored for a resident receiving an anticoagulant (blood thinner) and aspirin, (a non-steroid anti-inflammatory drug [NSAID]), for 1 of 5 residents reviewed for unnecessary medications. (Resident #27) Findings include: The clinical record of Resident #27 was reviewed on 4/24/14 at 11:15 a.m. Diagnoses included, but were not limited to, open reduction internal fixation of left hip on 2/21/14, dementia with behaviors, hypertension, atrial fibrillation, osteoporosis, and diabetes. A review of the recapitulation of the physician's orders for April 2014 indicated Resident #27 received enoxaparin (an anticoagulant) 40 mg once a day starting 2/25/14, and aspirin (an NSAID) 81 mg daily starting 2/26/14. An order on 3/7/14 indicated the weight bearing status for Resident #27 was changed to weight bearing as tolerated. The recapitulation lacked orders for laboratory (lab) monitoring for bleeding times. During an interview with Registered Nurse (RN) #2 on 4/ 24/14 at 2:52 p.m.,		found to have been affected by the deficient practice? Resident #27 medication review completed by 5/15/14. Resident is no longer receiving an anti-coagulant per physician order. Labs within normal limits. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All other Residents have the potential to be affected. An audit of charts was conducted by Director of Nursing/designee to ensure bleeding times are being monitored for Residents receiving anticoagulants and aspirin. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Licensed nursing staff were provided inservice education on 5/12/14 and 5/13/14 regarding monitoring of bleeding times for Residents receiving anticoagulants and aspirin. This information will be covered during new licensed nursing staff orientation. Director of Nursing/designee will review daily all new admissions, readmissions, new physician orders, and order changes for anticoagulants to ensure bleeding times are being monitored. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and By what date	

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	RN #2 indicated Resident #27 did not have physician's orders to monitor lab values related to the combined usage of an anticoagulant and aspirin. During an interview with the DoN on 4/25/14 at 1:30 p.m., the DoN indicated Resident #27 was not monitored with laboratory testing as the medication enoxaparin was given until the weight bearing status was changed for the resident following the repair of the fractured hip. The DoN indicated the nurse practitioner and the physician had reviewed orders since the hospital admission and no orders were received to check laboratory values. The DoN indicated an order to check the laboratory values was received on 4/24/14, and the results were within normal limits so the medication enoxaparin was discontinued on 4/24/14. The Nursing 2014 Drug Handbook, copyright 2014, indications and dosages, for enoxaparin for patients with an acute illness who are at an increased risk for blood clots due to decreased mobility, included guidelines for treatment of enoxaparin for 6-11 days. Interactions included an increased risk of bleeding when used in conjunction with NSAID's, and monitoring of protime (PT) and International Normalized Ratio (INR)		the systematic changes will be complete? Anticoagulant CQI will be conducted weekly x 4 weeks, monthly x 2, then quarterly until continued compliance is met for 2 consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, then an action plan will be developed to ensure compliance. Date of compliance 5/28/14.	

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	should be completed. 3.1-48(a)(3)			
F000411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview, and record review, the facility failed to ensure dental services were provided for a resident who did not have dentures for 1 of 4 residents who met the criteria for dental review. (Resident #36) Findings include: The clinical record of Resident #36 was reviewed on 4/22/14 at 9:22 a.m. Resident #36 was admitted to the facility following a hospital admission on	F000411	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Resident #36 dental appointment for new dentures was arranged and Resident seen by dentist on 5/8/14 and 5/13/14 for denture fitting. Facility will continue to assist Resident with dental appointments including arranging transportation to and from dentist office. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective	05/28/2014

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	12/22/13. Diagnoses included, but were not limited to, cholecystectomy (removal of the gallbladder) due to cholelithiasis (gallstones) with acute cholecystitis (inflammation of the gallbladder) and obstruction, acute pancreatitis, hypertension, chronic kidney disease, congestive heart failure, atrial fibrillation, anemia, and diabetes. A 5-day Minimum Data Set (MDS) assessment, completed on 12/29/13, indicated Resident #36 had a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. A 90 Day MDS, completed 3/18/14, assessed Resident #36 as having a BIMS of 6, indicating severe cognitive impairment, a decline from the 5-Day MDS assessment. During a Stage I interview on 4/23/14 at 11:00 a.m., Resident #36 indicated he had broken his dentures prior to admission to the facility, and had not been able to get them replaced. Resident #36 indicated he had difficulty chewing his food without having dentures, and the facility had started, "grinding up his meats," which seemed to help. Resident #36 indicated he had discussed his dentures with the staff at the facility, but was informed the facility could not help him, and he was going to take care of		action(s) will be taken? All Residents have the potential to be affected. A dental services audit was conducted by Social Service Director/designee 5/15/14 to ensure all Residents in need of or requesting dental services have arrangements to be seeen by dentist either in facility or outside facility. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Facility Activity Report will be reviewed daily by the Director of Nursing/designee to ensure Resident new onset dental care needs have been documented, careplanned appropriately, and dental services arranged. The Interdisciplinary Team will review current Residents, new admissions, and readmissions to identify Residents with needs for dental services and/or dentures. Careplans will be devleoped and/or revised accordingly. The Interdisciplinary Team will ensure Residents receive needed dental appointments and arrange transportation to and from dentist office if seeing outside dental provider. Facility will assist short-term stay Residents with dental services as needed outside the facility prior to discharge from the facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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	getting a new pair after he discharged. During an interview with Registered Nurse (RN) #6 and the Director of Nursing (DoN) on 4/22/14 at 2:20 p.m., RN #6 indicated Resident #36 had asked about dentures some time ago, but since he was going home he was informed he was not eligible for the dental program utilized by the facility. RN #6 indicated the daughter of Resident #36 was supposed to provide the facility with the name of a dentist for further consultation, but had failed to provide the information. RN #6 indicated Resident #36 had filed a grievance (a concern) with the facility related to obtaining dentures. During an interview with the DoN on 4/24/14 at 2:45 p.m., the DoN indicated Resident #36 had declined dental services upon admission to the facility 12/22/13. The DoN provided a copy of a form titled "General Dental Consent Form," and indicated the signature was that of Resident #36. The DoN also provided a copy of a form titled "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM," dated 2/21/14, at 2:30 p.m. The information on the form indicated Resident #36 had voiced a concern regarding issues with his gums due to not having dentures. Resident #36 indicated		put into place; and By what date the systematic changes will be complete?Dental Services CQI audit will be completed weekly x 4 weeks, monthly x 2, then quarterly until continued compliance for 2 consecutive quarters. Audit will be reviewed by the CQI committee. If threshold of 95% is not achieved, then an action plan will be developed to ensure compliance. Date of compliance 5/28/14.	

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	he had lost his dentures prior to admission to the facility. Section II of the form signed and dated 2/25/14, which included action taken by the facility, indicated, "...resident is planning on going home so he doesn't qualify for in house dental care left msg [message] with dtr [daughter] ... to inform of need for dental care once dc'd [discharged] home...." On 4/25/14 at 11:58 a.m., the social service designee (SSD) provided the Dental Services Policy and Procedure, dated 1/2006, and indicated the policy was the one currently used by the facility. In the section titled "...POLICY The facility provides dental services to meet the oral health needs of the each resident. PROCEDURE...The facility maintains an outside resource to provide dental services to meet the needs of each resident...Resident's with lost, poorly fitting, or damaged dentures are promptly referred to the dentist. The facility will assist the residents in making dental appointments, arranging transportation to and from the dentist's office." 3.1-24(a)(3)			
F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS			

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	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure insulin vials and eye drop bottles were labeled with the date they were opened, and narcotic medications were reconciled, according to the facility policies for 2 of 4 medications carts	F000431	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Resident #7, Resident #97, Resident #88, Resident #46, Resident #6, and Resident #123 now have medication labels with date	05/28/2014

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	reviewed. (200 Hall medication cart and 500-600 Halls medication cart) Findings include: 1. A. During an observation of the 200 Hall medication cart on 4/29/14 at 10:30 a.m., with RN #1, the following medications did not have a date opened or expiration date on them: Lantus insulin for Resident #7 Novolog insulin for Resident #97 Lantus and HumaLog insulins for Resident #7 2 Natural Tears eye drops for Resident #88 Artificial Tears eye drops for Resident #46 Timolol 0.25% eye drops for Resident #6 Systane Ultra eye drops for Resident #123. During an interview with RN #1 at that time, she indicated they were supposed to label insulin vials and eye drop bottles with the date they were opened. 1. B. During an observation of the 500-600 Hall medication cart on 4/29/14 at 10:55 a.m. with Licensed Practical Nurse (LPN) #5, a vial of HumaLog insulin for Resident #83 did not have a		opened. Controlled Drugs Count Received form being utilized to indicate control drugs are counted at each shift by two members of the nursing staff, the nurse/medication aide coming on duty and the nurse/medication aide going off duty, as well as signatures verify that an actual count has been made and the count is the same as that indicated on the individual control drug record. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All Residents have the potential to be affected. An audit of medication carts and medication room refrigerators completed by Director of Nursing/designee to ensure all open medications had date opened on them. An audit of Controlled Drug Count Received completed by Director of Nursing/designee to ensure narcotic medications reconciled. Licensed nursing staff provided inservice education on 5/12/14 and 5/13/14 by Director of Nursing regarding proper medication labeling with date when opened and narcotic medication reconciliation per Controlled drug Count Received signatures. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Licensed	

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	date opened or expiration date on it. During an interview with LPN #5 at that time, she indicated insulin vials were supposed to be labeled with a date when they were opened. On 4/29/14 at 11:40 a.m., the Nurse Consultant provided a Labeling of Medication, dated 7/2011, and indicated the policy was the one currently used by the facility. This policy indicated, "Labeling for all medications must be:...Expiration date of all time dated drugs...to establish guideline for medications after the packaging has been opened that are in accordance with the manufacturer's guidelines...medication must be checked by the facility regularly for expiration dates...all medications with shortened expiration dates after opening must be marked with the date opened..." 2. During this same observation of medication carts on 4/29/14 at 10:30 a.m., a review of the Controlled Substance Audits for each cart indicated spaces for oncoming and outgoing nurses to sign after counting the controlled substances in the cart, and spaces for them to indicate, " 'OK' if correct State problem if incorrect." The 200 Hall medication cart Controlled		nursing staff provided inservice education on 5/12/14 and 5/13/14 by Director of Nursing regarding proper medication labeling with date when opened and narcotic medication reconciliation per Controlled Drug Count Received signatures. This information will be covered during new licensed nursing staff orientation. Licensed nurses/unit managers will check medication room refrigerators and medication carts each shift for medication label open with date and narcotic medication reconciliation. Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and By what date the systematic changes will be complete? Director of Nursing/designee will monitor medication label open dates with Medication Storage CQI and will monitor narcotic medication reconciliation with Narcotic Count CQI weekly x 4 weeks, monthly x 2, then quarterly until continued compliance is met for 2 consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, then an action plan will be developed to assure compliance. Date of compliance	

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	Substance Audit for April, 2014, indicated the following: There were no signatures for oncoming and outgoing nurses on the night shift, April 5, 2014. There were no signatures for oncoming and outgoing nurses on the evening shifts, April 24 and April 25, 2014. There was no signature for the outgoing nurse on the day shift, April 28, 2014. The spaces where the nurses were to indicate "OK" if the counts were correct were not filled in on the evening shift, April 8, 24 and 25, and the night shift, April 5 2014. During an interview with RN #1, on 4/29/14 at 10:45 a.m., she indicated the nurses were supposed to sign the form after they counted the controlled substances, enter "OK" if the counts were correct. b. The 500-600 halls medication cart Controlled Substance Audits for March, 2014, and April, 2014, indicated the following: There were no signatures for the oncoming and outgoing nurses on the day		5/28/14.	

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	shift, March 6, 26, 28 and 31, and April, 30, 2014. There were no signatures for the oncoming and outgoing nurses on the evening shift March 26 and April, 25, 2014. There were no signatures for the oncoming and outgoing nurses on the night shift March 17, 22, 23, 27 and 31,2014. There were no signatures for the oncoming and outgoing nurses on the day shift, April 30. There were no signatures for the oncoming and outgoing nurses on the evening shift, April 25, 29, and 30, 2014. There were no signatures for the oncoming and outgoing nurses on the night shift, April 18, 19, 25, 29 and 30, 2014. The spaces where the nurses were to indicate "OK" if the counts were correct were not filled in on the day shift, March 3 - 14, 17 - 22, 24 and 26, 2014, and on April 1 - 11, 14 - 26, and 28 - 30, 2014. There were no indications the counts were "OK" on the evening shift, March			

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	26, 30 and 31, 2014, and April 14, 15, 16 and 25, 2014. There were no indications the counts were "OK" on the night shift, March 4, 17, 22, 23, 27, and 31, 2014, and on April 6, 7, 11, 12, 19, 19, and 25, 2014. During an interview with LPN #5, on 4/29/14 at 11:10 a.m., she indicated the nurses were supposed to sign the form after they counted the controlled substances, enter "OK" if the counts were correct. Directions on this Controlled Substance Audit form indicated, "Important Control drugs are counted at each shift by two members of the nursing staff, the nurse/medication aide coming on duty and the nurse/medication aide going off duty. Signatures by the nurse/medication aides verify that an actual count has been made and the count is the same as that indicated on the individual control drug record. Note any discrepancy in the comment section and report discrepancy to the Director of Nursing Services." During an interview with the Nurse Consultant on 4/29/14 at 11:40 a.m., she indicated the nurses were using an old form. She indicated there was a newer form they were supposed to be using			

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	which required only the signatures of the oncoming and outgoing nurses, but no spaces to indicate if the count was correct. She indicated the nurses' signatures alone, on the new forms, verified the count was correct. This undated form, titled, "Controlled Drugs - Count Record," was provided by the Director of Nursing Services at the time of exit, 4/29/14 at 3:00 p.m. On 4/29/14 at 111:54 a.m., the Executive Director provided a Storage of Scheduled II/Controlled Medications policy, dated 7/2011, and indicated the policy was the one currently used by the facility. The policy indicated "...All scheduled II/controlled medications must be checked (counted) for accountability at each change of shift by the nurse going off duty and the nurse coming on duty. Documentation of the audit will be completed on the appropriate form..." 3.1-25(e)(3)			
F000504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on interview and record review, the facility failed to ensure a physician's	F000504	What corrective action(s) will be accomplished for those Residents found to have been affected by	05/28/2014

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	order was obtained for laboratory testing completed on 1 of 5 residents reviewed for unnecessary medications. (Resident #27) Findings include: The clinical record of Resident #27 was reviewed on 4/24/14 at 11:15 a.m. Diagnoses included, but were not limited to, open reduction internal fixation of left hip on 2/21/14, dementia with behaviors, hypertension, atrial fibrillation, osteoporosis, and diabetes. A review of the recapitulation of the physician's orders for April 2014 indicated Resident #27 received enoxaparin (an anticoagulant) 40 mg once a day starting 2/25/14, aspirin, (a nonsteroidal anti-inflammatory drug), 81 mg daily starting 2/26/14, insulin glargine (Lantus, a drug used to treat high blood sugars) 14 units at bedtime daily, insulin lispro (Humalog, a drug used to treat high blood sugars) 10 units twice a day, and ramipril (a drug used to treat high blood pressure) 10 mg daily. Resident #27 had physician's orders for twice daily blood glucose testing. The recapitulation lacked orders for laboratory (lab) monitoring of medications.		the deficient practice? Resident #27 has physician orders for scheduled lab draws. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All other Residents have the potential to be affected. All Residents charts have been audited by Director of Nursing/designee to ensure physician orders are in place for all scheduled lab draws. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Licensed nursing staff provided inservice education on 5/12/14 and 5/13/14 regarding properly scheduling and discontinuing previous labs when new physician orders are received. This information will be covered during new licensed nursing staff orientation. Licensed nurses/unit managers will review lab orders daily for current Residents, new admissions, and readmissions to ensure new lab orders per physician are scheduled and discontinued lab orders per physician are cancelled with lab provider. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and By what date the systematic changes will be complete? A Lab CQI audit tool	

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	Resident #27 had lab results in the clinical record for a basic metabolic panel, (BMP) a complete blood count, (CBC) and a hemoglobin A1C completed on 3/12/14 and a CBC and and a thyroid stimulating hormone (TSH) 3/21/14. A physician's order was not found for the lab tests. During an interview with Registered Nurse (RN) #2 on 4/ 24/14 at 2:52 p.m., RN #2 indicated Resident #27 did not have physician's orders to monitor lab values as indicated by the medications administered. RN #2 indicated the labs drawn and tested on 3/12/14 and 3/21/14 for Resident #27 were completed because the facility failed to notify the lab company of the lack of a current physician's order when the resident was re-admitted to the facility on 2/25/14. On 4/25/14 at 1:30 p.m., the DoN provided a copy of the lab requisitions for 3/12/14 and 3/21/14. The requisitions included a signature of a licensed nurse. The DoN indicated the signature of the nurse was verification the nurse was notified Resident #27 had blood drawn on 3/12/14 and 3/21/14 for lab testing. The DoN indicated the nurse should have checked for a current physician's order prior to the collection of the blood for testing.		will be completed weekly x 4 weeks, monthly x 2, then quarterly until continued compliance is met for 2 consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, then an action plan will be developed to assure compliance. Date of Compliance 5/28/14.	

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	3.1-49(f)(1)			